**M E M O R A N D U M**

TO: Hon. Janet Napolitano
Governor of Arizona

FROM: Blue Ribbon Panel

DATE: March 4, 2004

SUBJECT: Preliminary Report of Findings and Recommendations Relating to the January 18 - February 1 Hostage Incident at the Morey Unit, Lewis Prison Complex

You have charged us with conducting a thorough review of the Department of Corrections and recommending a comprehensive plan of corrective action to improve security throughout the State's prison system. Attached is a preliminary report that analyzes what occurred on the morning of January 18, 2004 at the Morey Unit of the Lewis Prison Complex, a brief description of what unfolded over the next 15 days and how this incident resulted in a successful and peaceful resolution without loss of life. It includes initial findings and specific recommendations to prevent such an incident from occurring again. The report also identifies several other systematic problems with the State correctional system that require further study and analysis. We look forward to your direction on how you would like to proceed with that stage of the investigation.

Any responsible discussion of corrections policy and prison administration, in Arizona or any other state, must begin with a fundamental acknowledgement: prison work is inherently dangerous.

It is also vitally important. Public safety – a fundamental goal of government – depends not only on government's ability to capture and convict criminals, but also on its skill in appropriately separating criminals from the public and from each other. Thus, corrections is – or, rather, should be – a co-equal partner with law enforcement in the endless quest to protect law-abiding citizens from lawbreakers.

Yet, while law enforcement agencies and officers generally (and rightfully) bask in the warm glow of good will among the people they serve and the branches of government that fund them, a corrections department is essentially one of the most neglected of state government agencies: no built-in constituency, and no advocate apart from itself. Strategically out of sight and conveniently out of mind, a corrections department also offers no reason to attract the public's attention … until something goes wrong.

On the morning of January 18, 2004, at the Morey Unit of the Lewis Prison Complex in Buckeye, Arizona, something went wrong. More accurately, many things went wrong: some spontaneous and isolated, others the result of long-term institutional neglect and decay. As a consequence of situational errors and complacency on the part of some correctional officers and years' worth of bad decisions at all levels of the Arizona Department of Corrections, two dangerous inmates, initially armed only with homemade weapons and a kitchen utensil, subdued five correctional officers, took two of them hostage, seized a virtually impenetrable tower at one of Arizona's most modern, allegedly state-of-the-art prison facilities, and held the world at bay for 15 days before surrendering.

It has been said that "success has many fathers, while failure is an orphan." That does not apply here. The incident at the Morey Unit evolved out of a rich combination of complacency, inexperience, lack of professionalism, inadequate staffing, vague security procedures, poor training, lack of situational awareness, premature promotions, non-competitive pay, ineffective communication, malfunctioning equipment, high inmate-to-officer ratios, bad architectural design and myriad other causes detailed in the report that accompanies this memorandum. Some of the causes were specific to the Morey Unit, which has problems. But Morey was not only *the* problem; our review of how the Department of Corrections has gone about its business through multiple administrations leads us to believe that a crisis situation of some kind, at some Department of Corrections facility, was inevitable.

Having recognized what went wrong, it is vital that we also acknowledge what went right. There was no loss of life. There was no escape from the facility. There was no loss of control of a prison facility, or of a unit, or of even a housing unit. The public was never at a heightened risk. In the wake of the hostage taking, supervisors and officers at the Morey Unit – many of whom we find to be passionate about and dedicated to their work – distinguished themselves in keeping order and preventing a high-risk situation from reaching a critical stage. Further, the skill exhibited by, and the level of cooperation among, corrections and law enforcement agencies across Arizona was exemplary. The peaceful resolution of the hostage situation is a tribute to their ability and professionalism in an extremely difficult environment.

As we mentioned earlier, the Morey situation's roots can be found in years of neglect, complacency and indifference within the Department of Corrections. Director Schriro informed the panel that she is already implementing significant changes based on her internal assessment. We believe that the Morey incident served to accelerate a reform process that was already underway. The panel was troubled to hear some of the findings resulting from her initial assessment reflecting continued complacency and un-professionalism and believe it signifies a culture that is evolved at Lewis that requires immediate and fundamental change.

In carrying out your charge, we conducted eight hearings (including four field hearings at correctional facilities) at which we heard from nearly one hundred witnesses during fifty hours of testimony; received over 150 emails from correctional employees; and produced the preliminary set of findings and recommendations that follow. All hearings and briefings have been open to the media.

Any and all materials and documents generated by this panel are public documents and were forwarded to the Legislature this morning to facilitate any inquiry that it may conduct.

We have started an important process, and we look forward to working with you in bringing it to a satisfactory conclusion for the benefit of all Arizonans.